Houk Chiropractic Clinic Non-Coverage Notice

Patient Name: _____

Reason(s) service(s) may not be covered:

- ☐ You may have exceeded the benefits in your plan.
- ☐ No authorization/referral is present for this date-of-service.
- ☐ We are not able to verify your benefits at this time (coverage is not known)
- ☐ You wish to bill your health insurance for a service that has been stated as non-covered by your insurance and agree to pay the remaining balance if it is denied.
- ☐ Authorization is pending for the recommended series of treatment.
- ☐ Insurance clinical review may determine that your current level of care does not meet established criteria for coverage. Maintenance, recreational, sedative, or palliative care will not be covered as determined by your insurance, and the claim will expectedly deny.
- ☐ Coverage is pending verification/approval of your L&I Claim
- ☐ Coverage is pending verification/approval of your Auto Injury Claim
- ☐ Other, Please explain _____

Costs: 98940 ($55.00) 98941($65.00) 98942 ($75.00) 98943 ($45.00) 97124 ($70-$140.00)

Low-Level Laser Therapy – This service will not be billed to commercial health insurance ($90)

By signing below, I understand that service(s) provided by Houk Chiropractic Clinic may not be covered by my insurance company for the reason(s) stated above. I choose to review service(s) knowing that is may not be covered. The undersigned shall be responsible for payment and shall make the necessary financial arrangements with the healthcare provider to pay for these services.

Signature: _____ Date: _____

(Must be 18 years or older to sign)

Relationship to patient: _____ Staff Initial:_____

- ☐ I am choosing not to bill my health insurance for services provided. I am responsible for payment and I cannot request to retro-bill if my insurance is not billed and the treatment falls outside of timely filing parameters.

Signature: _____ Date: _____

(Must be 18 years or older to sign)

Relationship to patient: _____ Staff Initial:_____

Houk Chiropractic Clinics – Patient Condition Questionnaire NP MVC NP

Name: _____ Birth Date: _____ Today's Date: _____

Height: _____ Weight: _____ Date accident occurred: _____

Office Use Blood Pressure: _____ Heart Rate: _____ Time accident occurred: _____ : _____ AM PM

Describe how the accident took place: _____

_____

_____

_____

Describe your condition and symptoms caused by the accident: _____

_____

_____

Have you missed work or school due to your injuries or condition? No Yes

_____

Auto-Accident Specific Information	
Were you the:	☐ Driver ☐ Passenger ☐ Pedestrian
Automobile you were in:	Year: _____ Make: _____ Model: _____
Damage to your car:	☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender
Damage amount estimate:	$ _____ ☐ Minor ☐ Major ☐ Total
Other automobile:	Year: _____ Make: _____ Model: _____
Damage to other car:	☐ Front ☐ Rear ☐ Pedestrian ☐ Driver Side ☐ Passenger Side ☐ Bumper ☐ Fender
Damage amount estimate:	☐ Minor ☐ Major ☐ Total
Where did the accident happen?	Street names: _____ City, State: _____
Was it:	☐ Controlled intersection ☐ Uncontrolled ☐ Not an intersection
Was there a traffic light?	☐ None ☐ Green ☐ Red ☐ Turn Arrow ☐ Stop Sign
Were you:	☐ Slowly Moving ☐ Moving ☐ Stopped
Speeds:	How fast were you going? _____ MPH How fast were they going? _____ MPH
Time of Day:	☐ Day ☐ Twilight ☐ Night
Weather conditions:	☐ Clear ☐ Cloudy ☐ Rainy ☐ Sunny
Street surface:	☐ Dry ☐ Wet ☐ Slick ☐ Icy ☐ Pavement ☐ Other: _____
Type of impact?	☐ Rear End ☐ Front ☐ Side Impact ☐ Roll Over
Brakes on impact?	☐ Locked Tight ☐ Loosely Applied ☐ None
How far did your car move?	☐ Did not move ☐ Moved 1-5 ft ☐ Moved 6-10 ft ☐ Moved over 10 ft
Seat Belt/Shoulder harness:	☐ Yes ☐No **Headrest:** ☐ Yes ☐ No **Headrest Position:** ☐ Up ☐ Down
Is the car equipped with airbags?	☐ Yes ☐No **Did they deploy?** ☐ Yes ☐ No
Did you see the impact coming?	☐ Yes ☐ No **Did you brace yourself for impact?** ☐ Yes ☐ No
On impact, your head was looking:	☐ Ahead ☐ Behind ☐ Up ☐ Down ☐ To the Right ☐ To the Left

Name: _____ Today's Date: _____

On impact, were you: ☐ Thrown forward ☐ Thrown backward ☐ Thrown sideways ☐ Other: _____

Did your body hit anything in the car? ☐ Yes ☐ No Body part:_____ What did it hit? _____

Head trauma? ☐ Yes ☐ No Loss of consciousness? ☐ Yes ☐ No If yes, for how long? _____

Do you remember accident happening? ☐ Yes ☐ No

Hospital: ☐ Yes ☐ No Name of hospital: _____ How long there? _____

Taken by ambulance? ☐ Yes ☐ No

X-rays taken? ☐ Yes ☐ No X-ray areas: ☐ Neck ☐ Mid-back ☐ Low back ☐ Other:

Medication given? ☐ Yes ☐ No Rx: _____

Other instruction from your doctor: _____ Follow-up? _____

Describe your pain: ☐ Burning ☐ Sharp ☐ Dull ☐ Ache ☐ Stabbing ☐ Radiating ☐ Throbbing ☐ Other

What aggravates it? _____

What relieves it? _____

Have you ever had this same or similar condition before? ☐ No ☐ Yes If yes, when? _____

Please describe your condition at that time: _____

_____

Please indicate any other health care providers you have seen for this condition or these symptoms:

Provider's Name	Type of License	Date of last visit
_____	_____	_____
_____	_____	_____

In the past 14 days, have you experienced any of the following:					
□ Headache	□ Dizziness	□ Light Bothers Eyes	□ Diarrhea	□ Head seems too heavy	□ Neck Pain
□ Loss of Memory	□ Clumsiness	□ Feet Cold	□ Neck Stiff	□ Tingling in arms/hands	□ Ears Ring
□ Hands Cold	□ Sleeping Problems	□ Tingling in legs/feet	□ Face Flushed	□ Nausea	□ Back Pain
□ Numbness in arms/hands	□ Buzzing in Ears	□ Constipation	□ Nervousness	□ Numbness in legs/feet	□ Loss of Balance
□ Cold Sweats	□ Tension	□ Shortness of Breath	□ Fainting	□ Fever	□ Fatigue
□ Irritability	□ Loss of Smell	□ Chest pain/rib pain	□ Pain in arms/hands	□ Pain in legs/feet	□ Jaw pain
□ Loss of strength - arms	□ Burning muscle pain	□ Loss of strength - legs	□ Difficulty swallowing	□ Sharp/shooting pain	
OTHER:					
□ Worst Headache Ever	□ Vertigo	□ Double/Blurred Vision	□ Weight Loss	□ Vomiting	□ Minor/Major Fall
□ New Type of Headache	□ Speech Problems	□ Difficulty Walking	□ Stomach Pain	□ Change in Bladder/Bowel	□ Head Trauma

Name: _____ Today's Date: _____

Medical History

Have you ever been to our office before? ☐ No ☐ Yes Date of your last physical exam: _____

List any previous accidents (automobile, on-the-job injuries, falls, sports injuries, etc.) and provide the accident date:

1) _____ Date: _____

2) _____ Date: _____

3) _____ Date: _____

Please list all surgeries, hospitalizations, and serious illnesses: _____

_____

_____

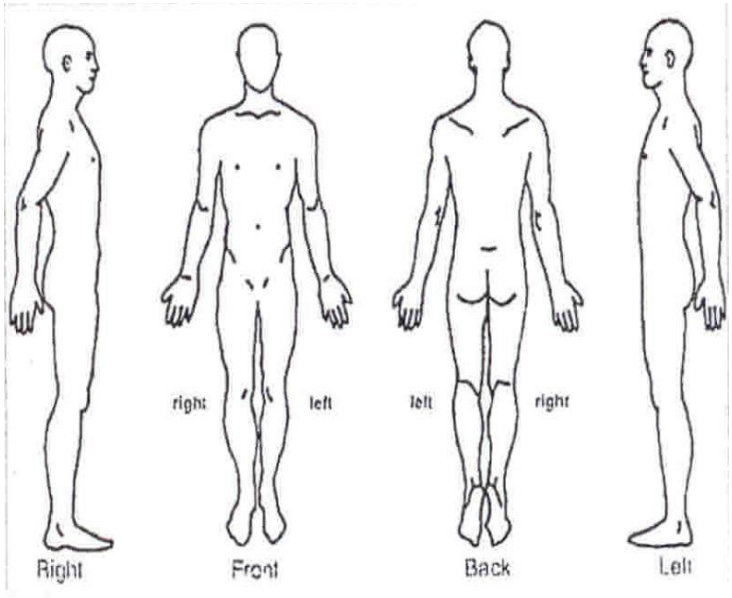
Please list your allergies: _____

What medications are you currently taking?	Please give the purpose for the medication.
_____	_____
_____	_____
_____	_____
_____	_____

Do you now or have ever had:

☐ Heart Disease	☐ Diabetes	☐ Cancer	☐ Stroke	☐ High Blood Pressure	☐ Thyroid Problems
☐ Tuberculosis	☐ Prostate Disorder	☐ Kidney Problems	☐ Asthma	☐ Ulcer	☐ Seizure Disorder

Please indicate the locations of your pain on the body diagram below.



ON A SCALE OF 1 to 10 with 10 being the worst possible pain, please rate the severity of your symptoms in the body regions that are affecting you.

_____ Headache	_____ Shoulder Pain
_____ Neck Pain	_____ Upper Arm Pain
_____ Upper Back Pain	_____ Lower Arm Pain
_____ Mid Back Pain	_____ Wrist Pain
_____ Lower Back Pain	_____ Hip Pain
_____ Upper Leg Pain	_____ Ankle/Foot Pain
_____ Lower Leg Pain	_____ Other

Thank you for taking the time to provide us this information.

Name: _____ Today's Date: _____

Houk Chiropractic Clinics – Review of Symptoms

Allergic-Immunologic: □ **NONE**

□ Hives/Eczema □ Hay Fever □ Catch cold easily □ Frequent Sinus Trouble □ Frequent Influenza
□ HIV □ AIDS □ Allergies

Cardiovascular: □ **NONE**

□ Murmur □ Chest Pain □ Palpitations □ Dizziness □ Shortness of Breath
□ Swollen Ankles □ Heart Attack □ Irregular Heart Beat □ Pressure Over The Chest □ Pain Down the Left Arm
□ High Triglycerides □ High Cholesterol □ Profuse Sweating □ Nausea □ Vomiting
□ Low Blood Pressure □ Fainting Spells □ High Blood Pressure □ Difficulty Lying Flat

Constitutional: □ **NONE**

□ Weight Loss □ Fatigue □ Fever

Ear, Nose, Throat: □ **NONE**

□ Difficulty Hearing □ Buzzing in Ears □ Ringing in Ears □ Vertigo □ Sinus Trouble □ Nasal Stuffiness
□ Hearing Loss □ Ear Pain □ Mouth Sores □ Hoarseness □ Nose Bleeds □ Dental Problem
□ Frequent Sore Throat □ Difficulty Swallowing

Endocrine: □ **NONE**

□ Loss of Hair □ Heat/Cold Intolerance □ Hypothyroidism □ Hyperthyroidism □ Diabetes □ Goiter

Eyes: □ **NONE**

□ Glasses/Contacts □ Eye Pain □ Light bothers eyes □ Double Vision □ Cataracts □ Vision Problems □ Glaucoma

Gastro-Intestinal: □ **NONE**

□ Heartburn/Reflux □ Nausea/Vomiting □ Constipation □ Change in BMs □ Diarrhea
□ Black or Bloody BM □ Gallbladder Problem □ Liver Problem □ Hepatitis □ Distress from greasy food
□ Ulcers □ Heartburn □ Hiatal Hernia □ Colitis □ Blood in the stool
□ Colon Cancer □ Abdominal Pain □ Burning in stomach □ Pancreatitis □ Jaundice
□ Pain over stomach □ Mucus in stool

Genitourinary: □ **NONE**

□ Burning/Frequency □ Blood in Urine □ Erectile Dysfunction □ Abnormal Discharge □ Leakage □ Incontinence
□ Kidney Infection □ Sexual Difficulty □ Kidney Stones □ Loss of libido

Hematology/Lymph: □ **NONE**

□ Easy Bruising □ Gums Bleed Easily □ Enlarged Glands □ Anemia □ Bleeding Disorder □ Sickle Cell Anemia □ Lymphoma

Musculoskeletal: □ **NONE**

□ Joint Pain/Swelling □ Stiffness □ Muscle Pain □ Neck Pain □ Stiff Neck □ Back Pain
□ Osteoarthritis □ Rheumatoid Arthritis □ Bone Spurs □ Broken Bones □ Compression fracture □ Head Injury
□ Back Injury □ Spinal trauma □ Birth trauma □ Birth defects □ Cancer □ Muscle weakness
□ Muscular Dystrophy □ Scheuerman's disease □ Scoliosis □ Lupus □ Spina bifida □ Spondylolisthesis
□ Arthritis □ Neck Injury □ Osteoporosis

Name: _____ Today's Date: _____

Neurological: □ **NONE**

□ Loss of strength □ Numbness □ Headaches □ Heavy Head □ Tremors □ Memory loss
□ Difficulty Speaking □ Multiple Sclerosis □ Parkinson's Disease □ Fainting □ Concussion □ Migraines
□ Disorientation □ Loss of Coordination □ Difficulty in walking □ Stroke □ Alzheimer's Disease □ Weakness
□ Disk Problems □ Light headed/Dizzy □ Epilepsy/Seizures □ Tingling

Psychiatric: □ **NONE**

□ Anxiety □ Depression □ Mood Swings □ Difficult Sleeping □ Nervousness □ Tension

Respiratory: □ **NONE**

□ Cough □ Coughing blood □ Wheezing □ Chills □ Chronic cough □ Pneumonia
□ Asthma □ Superficial breathing □ Chest Pain □ Tuberculosis □ Bronchitis □ Emphysema
□ Difficulty Breathing □ Lung Cancer

Integumentary (Skin): □ **NONE**

□ Rash/Sore □ Lesions □ Itching/Burning □ Skin Problems □ Slow Healing □ Bruise Easily
□ Psoriasis □ Change in moles □ Change in skin color □ Skin Cancer □ Scars □ Discolorations

Women: □ **NONE** Number of pregnancies _____ Currently pregnant: □ Yes □ No

□ Hot Flashes □ Vaginal Discharge □ Nipple Discharge □ Menstrual Cramps □ Premenstrual Depression
□ Lumps in breast □ Hysterectomy

Men: □ **NONE**

□ Burning on urination □ Difficulty in starting urine □ Dripping Urination □ Prostate Trouble □ Prostate Cancer

General: □ **NONE**

□ Recent weight gain □ Loss of sleep □ Recent weight loss □ Loss of Appetite □ Fatigue
□ Polio □ Rheumatic Fever □ Cancer of any kind

FAMILY HISTORY

	Headaches	Neck/Back Pain	Poor Posture	Scoliosis	Arthritis	Osteoporosis	Asthma	Cancer	Diabetes	Heart Disease	High Blood Pressure	High Cholesterol	Kidney Disease	Liver Disease	Other	Seizure	Stroke/TIA	Tuberculosis	Ulcer
Grandparent	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Father	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Mother	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Brother	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Sister	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Son	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Daughter	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
Half-sibling	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□	□

Houk Chiropractic Clinics – HIPAA Notice

Accident Information
Is your condition due to an accident? ☐ No ☐ Yes Date:
Type of Accident
☐ Auto ☐ Work ☐ Home ☐ Other
To whom have you made a report of your accident?
☐ Auto Ins ☐ Employer ☐ Workers Comp ☐ Other
Meaningful Use
Preferred language: ☐ English ☐ Other :
Smoking: ☐ No ☐ Yes # packs per ☐ day ☐ week ☐ month
Alcohol: ☐ No ☐ Yes # drinks per ☐ day ☐ week ☐ month
Race: ☐ White ☐ American Indian ☐ Alaska Native ☐ Black ☐ African American ☐ Asian ☐ Native Hawaiian ☐ Pacific Islander ☐ Other ☐ Decline
Ethnicity: ☐ Hispanic-Latino ☐ Not Hispanic-Latino ☐ Decline

Please let us know the name(s) of anyone we may release your information to:
Name:
Relation

Name:
Relation:

Name:
Relation:

May we leave a detailed voicemail? Y / N

HIPAA Privacy Practice Notice

The Practice:

A: Is required by federal law to maintain the privacy of your Personal Health History and to provide you with this Privacy Notice detailing the practice's legal duties and privacy practices with respect to your Personal Health History.

B: Under the privacy rule, may be required by State law to grant greater access or maintain greater restrictions provided under federal law.

C: Is required to abide by the terms of this Privacy Notice.

D: Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for all of your Personal Health History that it maintains.

E: Will distribute any revised Privacy Notice to you prior to implementation.

F: Will not retaliate against you for filing a complaint.

By signing my name below, I acknowledge receipt of a copy of this Notice, and I understand and agree to its terms.

All information provided on this document is true and correct to the best of my knowledge.

Assignment of Benefits

I authorize medical benefit payment, including Medicare, private and group insurance, or other health plan to Houk Chiropractic Clinic.

Print Name: _____

Signature: _____ **Date:** _____

Houk Chiropractic Clinics – Demographics

Patient Identification		
First Name:		MI:
Last Name:		
Nickname:		
Birth Date:	Age:	Sex: ☐ M ☐ F
Social Security #:		
Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
What is your condition related to? ☐ Auto Accident ☐ Accident in Someone Else's Home ☐ Other Accident ☐ Work Related ☐ Accident at Someone Else's Business ☐ Non Accident		

Patient Contact Information		
Home Address:		
City:	State:	Zip:
Mailing Address:		
City:	State:	Zip:
Home Phone:		
Cell Phone:	TEXT Y / N	
Email:		

Employment Information
Status: ☐ Full-time ☐ Part-time ☐ None ☐ Retired ☐ Self
Occupation:
Employer:
Work Address:
Work Phone:
Student Status: ☐ Full-time ☐ Part-time ☐ None

Spouse Information
Name:
Birth Date:
Home Phone:
Cell Phone:
Employer:
Occupation:
Work Phone:

Emergency Contact Information
Name:
Relation:
Birth Date:
Home Phone:
Work Phone:
Cell Phone:

Who may we thank for referring you to us?

How did you hear about us?
☐ NEWSPAPER ☐ SIGN ☐ TV ☐ RADIO ☐ MAILING ☐ COMMUNTIY EVENT ☐ OTHER:

Acknowledgement of Financial Responsibility

INDIVIDUAL'S FINANCIAL RESPONSIBILITY. I understand that I am financially responsible for time spent with ANY PROVIDER at Houk Chiropractic Clinic **unless** the appointment has otherwise been pre- determined a "consultation".

Should I choose to involve my health insurance, the deductible, co-pays coinsurance, or non-covered services are ultimately my responsibility. Payments are due at time of service unless otherwise discussed, or a financial arrangement has been made. If insurance coverage is discovered after my date of service, Houk Chiropractic will be willing to "retro" bill any dates of service within the timely filing limits established by my personal insurance company. I understand that it is my responsibility to provide Houk Chiropractic accurate insurance information and that failure to do so may result in a denial of my claim.

As stated by my insurance company, a "quotation of benefit is not a guarantee of coverage or payment" and is dependent upon eligibility and medical necessity. Patient responsibility is determined by the insurance company. Claims are processed, and current insurance policies are applied.

Any pre-collected funds will be applied to the date of service, and I will be billed the difference when applicable. I understand that any pre-collection is an estimate based on the quote from my insurance company, and a courtesy performed for me by Houk Chiropractic.

In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

_____

Signature of Patient or Authorized Representative / Date

_____

Print Name of Patient or Authorized Representative / Relationship to Patient

Houk Chiropractic Clinics

NPI: 1528046778, TIN: 91-11161034
3809 N Monroe Spokane WA 99205 *** 9720 N Nevada Spokane WA 99218
Monroe: 509-326-3795 *** Northpointe: 509-464-2273

Good Faith Estimate - 10/01/2025

Patient Name:			Date of Birth:			
Diagnosis						
Estimated Services and Items		**Date of Appointment**				
Description		**Service Code**	**Quantity**	**Expected Cost**		
				Payment plan	Time of service	
Evaluation New Patient		99204	1	$ 300.00	$ 255.00	
Lumbar X-ray 5 view		72110	P	$ 140.00	$ 119.00	
Lumbar 4 view		72100	P	$ 90.00	$ 76.50	
Thoracic X-ray		72070	P	$ 90.00	$ 76.50	
Cervical X-ray		72050	P	$ 130.00	$ 110.50	
Cervical X-ray 3 view		72040	P	$ 95.00	$ 80.75	
Full spine X-ray			P	n/a	$ 225.00	Full spine; other x-ray charges will not apply
Spinal adjustment		98940	P	$ 55.00	$ 50.00	$ reflects cost per visit
Laser Treatment		0552T	P/R	$ 53.00	$ 48.00	
Guasha Treatment		97140	P/R	$ 45.00	$ 40.00	
Cost of Initial Visit may be reduced based on Level of Evaluation/X-Ray needs						
Established patient evaluation		99214	R	$ 200.00	$ 170.00	
Lumbar X-ray 5 view		72110	R	$ 140.00	$ 119.00	
Lumbar 4 view		72100	R	$ 90.00	$ 76.50	
Thoracic X-ray		72070	R	$ 90.00	$ 76.50	
Cervical X-ray		72050	R	$ 130.00	$ 110.50	
Cervical X-ray 3 view		72040	R	$ 95.00	$ 80.75	Full spine; other x-ray charges will not apply
Full spine X-ray			R	n/a	$ 225.00	$ reflects cost per visit
Spinal adjustment		98940	R	$ 55.00	$ 50.00	4 unit (60 min) Massage /$ reflects cost per visit
Massage Therapy*		97124	P/R	$ 95.00	$ 90.00	
Future treatment costs dependent on frequency of care; Costs above reflect single visit pricing						
P-Primary Service R- Re-occurring services or item (valid for 12 months from date of this form)						

Disclaimers:

There may be additional items or services that we recommend as part of the course of care that must be scheduled or requested separately and are not reflected in this good faith estimate.

The information provided in this good faith estimate is only an estimate of items or services resonably expected to be furnished the time this good faith estimate was generated. Actual items, services, or charges may differ from the good faith estimate.

You have the right to initiate the patient-provider dispute resolution process if the actual billed charges are $400.00 more than the good faith estimate.

Patient Signature _____ **Date** _____

It is our policy to expect payment at time of service. We have prepared a payment plan for you. Our financial policy states: 20% or $ 75.00 of account balance, or whichever is greater, will be due each month. Default in regular monthly payments can result in collection procedures. Please contact our office if you have any further comments or questions. Patient Intials _____

☐ Patient opted to not receive Good Faith Estimate by mail prior to appointment -verbal estimate prior to visit was given. Staff Initial _____